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Commentary

The Health Mobility Is All True Mobility?

Comment on "Regional Incentives and Patient Cross-border Mobility: Evidence From the Italian Experience"

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Abstract

In their study, Brenna and Spandonaro analyzed the mobility into Italian regions. In particular, it analyzes the situation of 5 regions, with very different backgrounds. With this paper, we try to better define the meaning of health mobility and to find its underlying causes. Furthermore, we propose a strategy that could help in controlling mobility flows that currently are the source of health inequalities.

Keywords: Italian National Health Service, Mobility, Regional Strategies

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The article by Brenna and Spandonaro[1] describes the Italian situation regarding mobility. Italy has a national health system, with a strong regional autonomy, which allows citizens residing in a region to move to another to seek medical care. The study analyzes the 2 main reasons for the mobility: mobility due to proximity to the geographical border or mobility to centers of excellence.

Analysis of the mobility hospital in the Italian Regions has several methodological aspects[2]:

1. What is the meaning of "mobility"? It usually refers to an administrative concept, related to the financing of medical care access: admission to hospital in mobility occurs when a patient seek access to medical care in a region different from the one of residence, ie, the one of registration to the regional health system.
2. However, there are different definitions of mobility. Among these, perhaps, the best one is the one which defines it as moving away from the hospitals frequented by the majority of the population close to the place of residence; or, simply, mobility is an hospital admission at a certain distance from the place of residence.
3. These conceptual differences are important in relation to the fact that the Italian regions are very different in size and shape: mobility intended as the exit from the regional borders is obviously higher in smaller regions and in the ones with high ratio between perimeter and area.
4. In a region like Lombardy, hospitalization of a resident of Bormio (a little village located in the north mountain of the Region) in a hospital in Mantova (city in the south of the Region) is not to considered inter-regional mobility but it can represent a substantial mobility (a distance of 241 km).
5. Thus, it is important to distinguish between mobility that occurs near the regional borders where an hospital, albeit in a different region, sometimes is closer to a patient and medium to long range mobility.[3]
6. It should be also considered the fact that the place of residence does not always reflect well the place of the person's life. Many people reside in a region are domiciled somewhere else. In Lombardy, for example, one hundred thousand not residents have chosen a Lombard general practitioner medical. These ones will definitely choose to be admitted to a Lombard hospital and the apparent mobility does not reflect a true mobility, but only an administration and accounting mobility. This phenomenon is amplified by the fact that some people prefer to be hospitalized where progeny, parents or other relatives live.
7. Then, there are admissions due to sudden illness of people who are away from their homes either for work, tourism or other reasons. This rate of mobility is not very high but it could be relevant in particular contexts characterized by substantial outbound and inbound movements.
8. It also must be considered that mobility can be classified into nominal or substantial mobility; the latter is due to the lack of medical care offering in the area of residence or where is little trust in the hospitals close by.
9. Mobility is not the same for all types of admissions, but it differentiates greatly depending on the type or complexity of admission. We observe, for example, mobility from north to south for childbirth, because women, who have moved to the north, prefer giving, birth close to their native home and to their family of origin. On the other hand, there is definitely a mobility from south to north for admissions related to severe diseases, eg, such as cancer, due to the greater confidence in the structures of the north.
10. Then some regions dictate a mechanism of quotas that

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limits the number of admissions to private facilities for people who live in that regions while such access it is unlimited for nonresidents.

All these elements make the analysis of mobility flows in Italy very complex and thus possible measures to contain and control it are difficult to be implemented. Among these measures, border agreements to share the limits imposed on private structures from neighboring regions are becoming more common.

The phenomenon of patient mobility has highlighted, also, a very unfair situation among the regions. In some regions, patients receive all the quality care they expect while in others they do not. Moreover, in regions with lower quality facilities, some patients might take alternative routers/approaches/channels and others have to accept what is offered to them. The health migration causes enormous inconvenience both for the patient and for families.

From the economic point of view, the admittance in mobility is more expensive for the health regional system in the region of origin. From this prospective, delivery of healthcare in mobility economically favors the receiving (creditor) region that is providing the medical service but is not advantageous to the region where the patient resides (debtor). Indeed, even in the case of bilateral agreements between the outgoing and receiving regions, such agreements are limited in scope and do not cover entire population that is seeking medical care in mobility.

For private structures encouraging inbound mobility, often supported by various forms of promotion, can be a way to achieve a satisfactory employment level of their productive potential.

Mobility flows are affected also by the fact that patients can choose between public and private care structures. Moreover, the lack of precise data regarding this preference by the public makes the analysis of mobility glows more complicated. While the number of accesses to private care is recorded, we currently do not know what led to that preference in the first place, if it was a indeed deliberate or it was the consequence of long waiting lists for access to the national health system. There is a strong relationship between how to restrict the mobility and patient freedom in choosing where to get medical care. Even by warranting these freedom of care choice for patients, a right guaranteed by the Italian system, it could be possible to envisage a dual pronged strategy in order to control interregional flows. A co-payment system could be established to disincentives individual mobility. This proposed system is born out of the idea that penalties should work as an incentive for the debtor regions, in order to push them to improve the quality of healthcare services and to establish excellence centers.

Ethical issues

Not applicable.

Competing interests

Authors declare that they have no competing interests.

Authors' contributions

Both authors contributed equally to the production of this manuscript.

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